



# BENEFIT SUMMARY

January 1, 2009 ~ December 31, 2009

## \* \* \* STATE OF INDIANA \* \* \*

### GENERAL BENEFIT LIMITS

|   |  |
|---|--|
| Benefit Limit Per Lifetime ( <i>Excluding the separate Maximum Benefit for Organ &amp; Tissue Transplants</i> ) (limited to \$1,000,000 per contract year)..... | \$5,000,000                            |
| Deductible Per Calendar Year (waived for non-tobacco Employees and their dependents).....   | \$500 per person, \$500 per family     |
| Out-of-Pocket Maximum.....  | \$2,000 per person, \$4,000 per family |
| ♦ Copays do not apply toward the Deductible or Out-of-Pocket Maximum. ♦ Deductible applies to the Out-of-Pocket Maximum.  |  |

### PHYSICIAN OFFICE VISITS

|   |                                |
|---|--------------------------------|
| Primary Care Physician Office Visits (Professional Services Fee)..... | 100% Coverage after \$20 Copay |
| Visits to Specialist upon referral (Professional Services Fee).....   | 100% Coverage after \$20 Copay |
| Chiropractic ( <i>limited to \$750 per contract year</i> ).....       | 100% Coverage after \$20 Copay |

### PHYSICIAN OFFICE OTHER SERVICES

|  |                                  |
|--|----------------------------------|
| Including, but not limited to: Immunizations and injections; allergy tests and treatment; hearing exams; laboratory, X-ray & other diagnostic services; care of immediate medical need; mammogram, PSA and colorectal exams & testing..... | 100% Coverage (after Deductible) |
|--|----------------------------------|

### PHYSICIAN HOSPITAL SERVICES

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|--|----------------------------------|
| Physician Services for Surgery, Visits and Examinations..... | 100% Coverage (after Deductible) |
|--|----------------------------------|

### INPATIENT HOSPITAL SERVICES

|   |  |
|---|--|
| Semi-Private Room and Board.....  | 100% Coverage after \$500 Copay per Admission (after Deductible) |
| Services include: Private room if medically necessary, Operating, recovery rooms and other special units including intensive care |  |
| Maternity care, Hospital ancillary services including laboratory, x-ray, EKG and other diagnostic services                        |  |
| Other services including anesthesia, physical therapy and medications, Administration of blood and blood plasma                   |  |
| Non-experimental organ transplants when prior authorized  |  |

### OUTPATIENT SERVICES

|  |  |
|--|--|
| Outpatient Surgery.....  | 100% Coverage after \$250 Copay per Admission (after Deductible)                             |
| Outpatient services including laboratory, x-ray, EKG and other diagnostic services.....  | 100% Coverage (after Deductible)   |
| Other outpatient services for MRI, CT, PET and SPECT.....  | 100% Coverage after \$50 Copay (after Deductible)  |
| Emergency room services for life-threatening medical emergencies.....  | 100% Coverage after \$75 Copay per visit (after Deductible) [waived if admitted to hospital] |
| Immediate/Urgent Care Center visit.....  | 100% Coverage after \$35 Copay per visit (after Deductible)                                  |
| Alcohol & Drug Addiction.....  | 100% Coverage after \$20 Copay per visit (after Deductible)                                  |
| Hearing Tests.....   | 100% Coverage after \$20 Copay per visit (after Deductible)                                  |
| Allergy Testing.....   | 100% Coverage after \$20 Copay per visit (after Deductible)                                  |
| Only prepackaged allergy medicines requiring a prescription will be covered under prescription drug section. Serums are not covered under the prescription drug section. |  |

### MENTAL HEALTH SERVICES

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|---|--|
| Inpatient Mental Health Services for Evaluation.....  | 100% Coverage after \$500 Copay per Admission (after Deductible) |
| Outpatient Visits for Psychotherapy, Crisis Intervention or Psychiatric Testing.....        | 100% Coverage after \$20 Copay                                   |
| Psychiatric Intensive Outpatient Program (Ambulatory Level Two Mental Health Programs)..... | 100% Coverage after \$20 Copay                                   |

### SUBSTANCE ABUSE SERVICES

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|--|--|
| Inpatient Substance Abuse Services for Diagnosis and Detoxification..... | 100% Coverage after \$500 Copay per Admission (after Deductible) |
| Outpatient Visits for Evaluation or Crisis Intervention.....             | 100% Coverage after \$20 Copay (after Deductible)                |

### OTHER SERVICES

|   |   |
|---|---|
| Dialysis.....   | 100% Coverage after \$20 Copay (after Deductible)                             |
| Durable Medical Equipment.....  | 80% Coverage (after Deductible)   |
| Emergency Ambulance.....  | 100% Coverage after \$50 Copay per Transport (after Deductible)               |
| Family Planning including Infertility, Counseling, Testing to Diagnosis, Surgical Treatment & Sterilizations..... | 80% Coverage (after Deductible)   |
| Home Health Care in Lieu of Hospitalization.....  | 100% Coverage after \$20 Copay per day (after Deductible)                     |
| Hospice Care.....   | 100% Coverage (after Deductible)  |
| Morbid Obesity Surgery.....   | 80% Coverage plus applicable inpatient or outpatient Copay (after Deductible) |
| Prosthetic Devices and Corrective Appliances.....   | 80% Coverage (after Deductible)   |
| Physical, Occupational and Speech Therapy.....  | 100% Coverage after \$20 Copay per Visit (after Deductible)                   |
| Temporomandibular Joint Dysfunction or Disease (TMJ) when medically necessary and prior authorized.....           | Applicable office visit, inpatient or outpatient Copay (after Deductible)     |
| Transplants.....  | \$2,000 Copay up to a maximum benefit of \$1,000,000                          |

### PRESCRIPTION DRUGS

*Prescription drugs for up to 30-day supply. OTC Select, Generic and Select Prescription Drugs are available through the participating mail order pharmacy for two thirty (30) day supply copayments for a 90-day supply. Non-Select is available for three thirty (30) day supply copayments for a 90-day supply. To be covered, certain prescription drugs may require Prior Authorization.*

|   |  |
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| OTC Select Drugs.....   | \$5 Copay                                  |
| Generic Prescription Drugs.....                                 | \$10 Copay                                 |
| Formulary Brand Name Drugs and Formulary Diabetic Supplies..... | \$20 Copay                                 |
| Brand Name or Generic Non-Formulary Drugs.....                  | 60% Coverage (\$40 minimum, \$100 maximum) |
| Biopharmaceutical Drugs/Injectable Drugs.....                   | 80% Coverage                               |
| Diaphragms, Cervical Caps.....                                  | 80% Coverage                               |

